



***Bemidji Area Indian Health
Service
STRATEGIC PLAN
2001-2005***



***“An Indigenous Approach to
Health”***



This Strategic Plan was developed during a two-day retreat held October 23, 24, 2001, in Green Bay, Wisconsin, with representatives from the Indian Health Service, tribes and urban health programs.

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INTRODUCTION

The Bemidji Area Office (BAO) of the Indian Health Service (IHS) is located in Bemidji, Minnesota. It provides health care and funding to support health services to Indians and Alaska Natives residing in four states, Minnesota, Wisconsin, Michigan and Indiana. Currently, there are 34 federally recognized tribes in the BAO geographical area, with more tribes seeking recognition by the federal government. The total population served by the Bemidji Area IHS exceeds 75,000 individual patients. Local Tribal affiliations of BAO/IHS patients include the Chippewa/Ojibwe, Odawa, Winnebago, Sioux, Oneida, Ottawa, Potawatomi, Menominee, and Stockbridge-Munsee Mohican Band. Indian patients served at our Urban Health Centers and at some IHS and tribal facilities may represent tribal affiliations from all across the United States.

Health services are provided through a variety of means. The IHS directly operates two short-stay hospitals, two health centers and five health stations. Many tribes operate their own health services under the authority of the Indian Self-Determination Act of 1976 (PL 93-638). There are 13 health centers and 33 health stations operated by tribes. In addition, there are 5 urban Indian health programs which operate under the authority of Title V of the Indian Health Care Improvement Act. IHS and tribal health providers may also contract with private providers of health services for inpatient or specialty services not offered in those settings through the Contract Health Services (CHS) program. Oftentimes these various components of the Indian health delivery system are referred to as the IHS, tribal, urban (I/T/U) health delivery system.

The Bemidji Area first began a strategic planning process in consultation with tribes in 1993. This initial planning meeting set a new tone for the IHS Area Office, and marked a shift away from “planning for” to a more participatory system of “planning with” tribes and urban programs. Since then, the BAO has attempted to follow the directives and guidance provided through these important sessions to better serve IHS, tribal and urban providers in the area.

A second strategic planning session occurred in 1997. Again, the BAO convened IHS, tribal and urban providers to conduct its strategic planning through a highly participatory process. The outcome of the 1997 strategic planning sessions produced a shared vision that recognized the diversity of I/T/U programs through-out the Bemidji Area, and built upon common goals across the Area. The 1997 vision statement identified those important functions at the Area Office which must continue, such as contract oversight, budget formulation, advocacy, and other legislative mandates. Secondly, the vision outlined targeted services that the Area Office could provide to I/T/U’s through local investment of tribal shares. These functions included: coordination of public health functions; assistance with human resources; state-of-the-art communication and information systems; support for federal, state and I/T/U collaboration.

In reviewing the 1997 Plan, we discussed what worked and what did not work with regard to the planning process used in 1997. Changes were made to the 2001 approach to planning, and we believe these changes substantially improved the overall process:



What Worked in 1997	What Didn't Work in 1997
<ul style="list-style-type: none">▪ Review of plan by A.D. from time to time▪ Diversity of Involvement▪ Better communication between BAO/Tribes▪ Sharing of information from BAO – I/T/U (new admin. changing)▪ Tribes understand the budget and know where every dollar is – tribes now doing allocations of new money▪ Tribes as group solving problems i.e. eligibility, funds allocation	<ul style="list-style-type: none">▪ Mix of tribal sizes/geography differences▪ Didn't include all area staff (it was limited, staff helped develop the mission statement)▪ Follow-up to operationalize the plan, and how to implement▪ Need mechanism for getting ideas into <u>mix</u> – more small group dynamics needed▪ I/T/U > urban involvement was not as strong as tribal focus

Upon reviewing the progress made by the Area from 1997 to 2001, it was important to note that many important accomplishments were made in the areas targeted by the 1997 plan.

This pattern of conducting strategic planning in four-year intervals is an important component of the BAO overall commitment to tribal consultation and I/T/U involvement. Initial planning for the 2001 retreat sought to build upon previous efforts and make improvements for expanded local involvement. It was important to ensure that all I/T/U's across the Area were invited. The IHS Area Office also invited two regional associations, the Great Lakes Intertribal Council (GLITC) and the Michigan Intertribal Council (MITC).

This document represents the strategic plan developed by those IHS, tribal and urban participants at the retreat held October 23, 24, 2001 in Green Bay, Wisconsin. Over seventy participants attended the retreat. In addition to the Area Office and two regional councils, participants included tribal leaders, tribal health officials, urban health directors and board members, and local IHS staff.

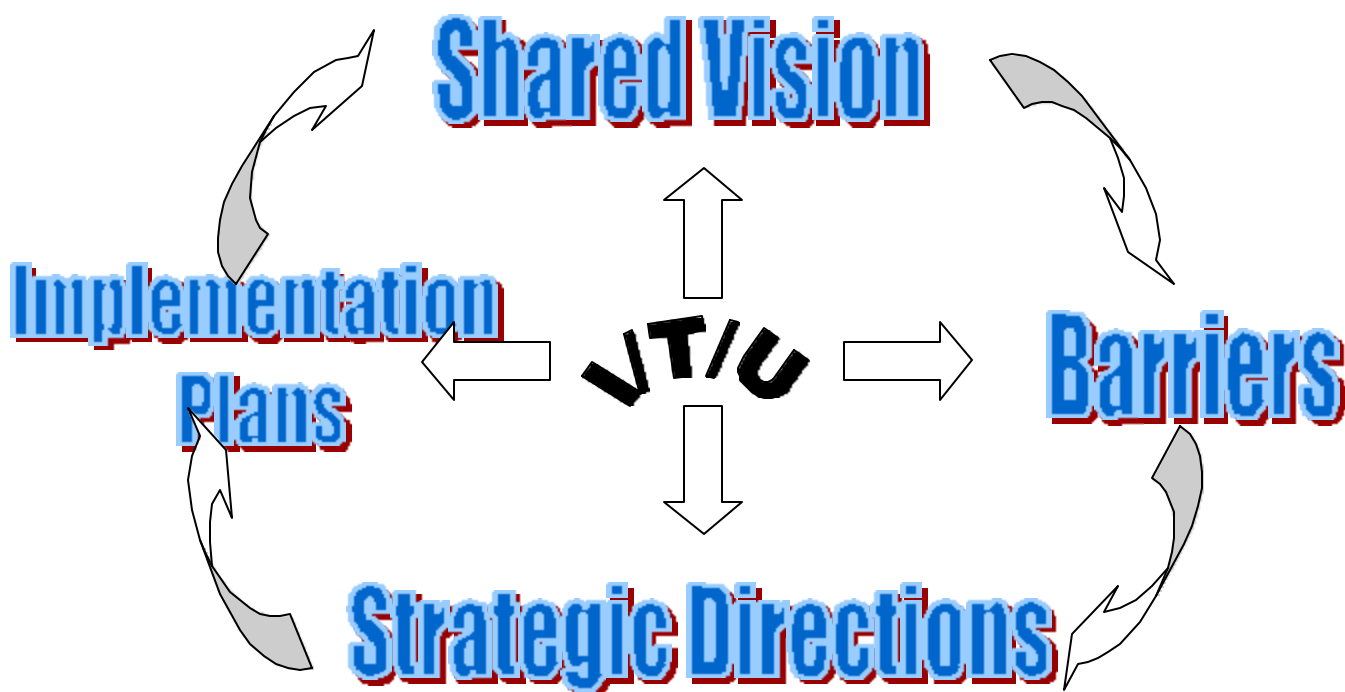
WHAT IS STRATEGIC PLANNING?

The Bemidji Area has found strategic planning, conducted in coordination and consultation with IHS, tribal and urban health providers is an important tool for building collaboratively for the future. As the BAO discovered in 1993 and 1997, the quality of the participation and ownership of the plan is crucial to the success and accomplishment of the plan's objectives. What makes a strategic plan, "strategic"?

Our planning process covered four basic steps. The first step was to develop a "Shared Vision" for the future. The second step identified the "Barriers and Challenges" that stand in the way of



our vision. The third step involved the development of “Strategic Directions” to circumvent obstacles and move toward our vision. The final step is a detailed “Implementation Plan”.



Why do a strategic plan? There are several basic reasons for strategic planning. It is most important to remember that the benefit of a strategic plan, is not the planning document, but the planning process. Benefits include:

- The generation of a specific plan, its strategies, solutions and actions;
- Greater levels of commitment by stake-holders to implement decisions and strategies;
- More innovation and creativity through group interaction and larger pool of ideas;
- A common framework for future decision-making, communication and problem solving;
- Encouragement of initiative, responsibility and accountability.

EXPECTATIONS OF THE PLANNING PROCESS

The IHS, tribes and urban participants in the Strategic Planning process came with a variety of expectations. In most cases their expectations were met during the two-day retreat. Some of these expectations are listed below:

- Learn more about IHS and its future – beyond just listing our needs



- Define Assets as well as needs
- Carry the Strategic Plan to the Tribes
- Better understand how to access all assets
- Maintain innovation in our planning and implementation
- Find I/T/U common goals
- Utilize tribal assets for urban programs and vice versa
- Recognize urban programs as our “Embassies” in the cities
- Look at technology and plan for upgrades
- Better communication between tribal governments and health efforts locally and regionally
- Address and understand the new threat of Bio-Terrorism in America
- Consider external changes in IHS and impact of Self-governance

STRENGTHS AND ASSETS OF THE BEMIDJI AREA

Before we began our planning process it was important to understand the strengths and assets we bring to this effort. The strengths of the I/T/U’s within the Bemidji Area represent the base upon which planning and implementation will be built. Briefly, the I/T/U’s described the strengths of the I/T/U’s represented in the Bemidji Area as follows:

- Innovative programs at the local level, such as ongoing work with pre-natal moms (pregnant women and prenatal care) and school-aged children on prevention (diabetes) (finding out new things)
- Tribal colleges and university systems
- A new hospital in Green Bay has opened potential for new negotiations and resources
- Ability to focus on a specific community
- Increased “skills” at the staff level
- Our Indian people and our survival-spirit that has kept us here
- Our willingness to include elders in our planning and vision
- True sense at IHS toward commitment to partnership and tribal control
- Bridge with universities under tribal direction
- IHS leadership development through the Phoenix Clinical Support Center
- Good grant writers locally who raise/secure new funding
- Strong leadership and team approach in the Area
- Ability of I/T/U’s to work together in the Area
- Passionate advocates for Indian health
- High level of commitment by staff
- Availability and practical application and impact of research (NIH)
- Facility construction for new clinics
- Information on health status is reliable
- Incredible history (20-30 years) in advancing our health status and people with experience
- Available space for health programs – diet/foods
- Dedication to care for our people



CHANGES SINCE 1997

Much has changed for the IHS, tribes and urban programs since their last strategic planning efforts in 1997. The environment in which this plan was conducted is important to understand. The challenges facing the I/T/U's in 2001 has changed from the challenges in 1997. The following are the identified changes since 1997:

- A new President, new government, new Congress at the national level
- New tribal councils and health directors locally
- More state involvement in Indian health issues
- Increased consultation with I/T/U's
- Increased number of tribes with new tribes recognized
- Decreased in Area staff from 135 to just 40 staff
- Technology changes and we struggle to keep pace
- War on terrorism impacts negatively on health budgets for clinics
- Tribal business development to develop pharmacy services
- More education of non-Indian population re: misperceptions about Indians
- Clinic expansions, increased staff and increased collections
- Inconsistent eligibility rules from location to location
- Degraded environmental quality
- Patient safety and quality changes and new rules
- Increase in total service population, more patients
- More business orientation of care
- Stress between tribal council and clinics due to many changes and need for better communication
- Increase in the number of tribes opting for Self-Governance compacts
- Michigan tribal health divisions active again

Based upon these initial discussions and our shared understanding of the realities of our environment, we began the four steps of the strategic planning process.



SHARED VISION

The first step in developing a strategic plan is to identify the “vision” for the future that is shared by those participating in the planning process. To identify our collective or “shared vision” for the future, we answered the following question.

**What administrative support systems and structure
do we see for the Bemidji area in four years?**

It is important to note, that this question does not presume that the IHS Area Office is the only resource to fulfill the I/T/U vision for an administrative support system. Such a system could include not only the IHS, but also intertribal associations and other cooperative I/T/U and private sector systems yet to be developed.

The following vision statement best represents the shared response from participants to the question posed above.

VISION FOR THE FUTURE

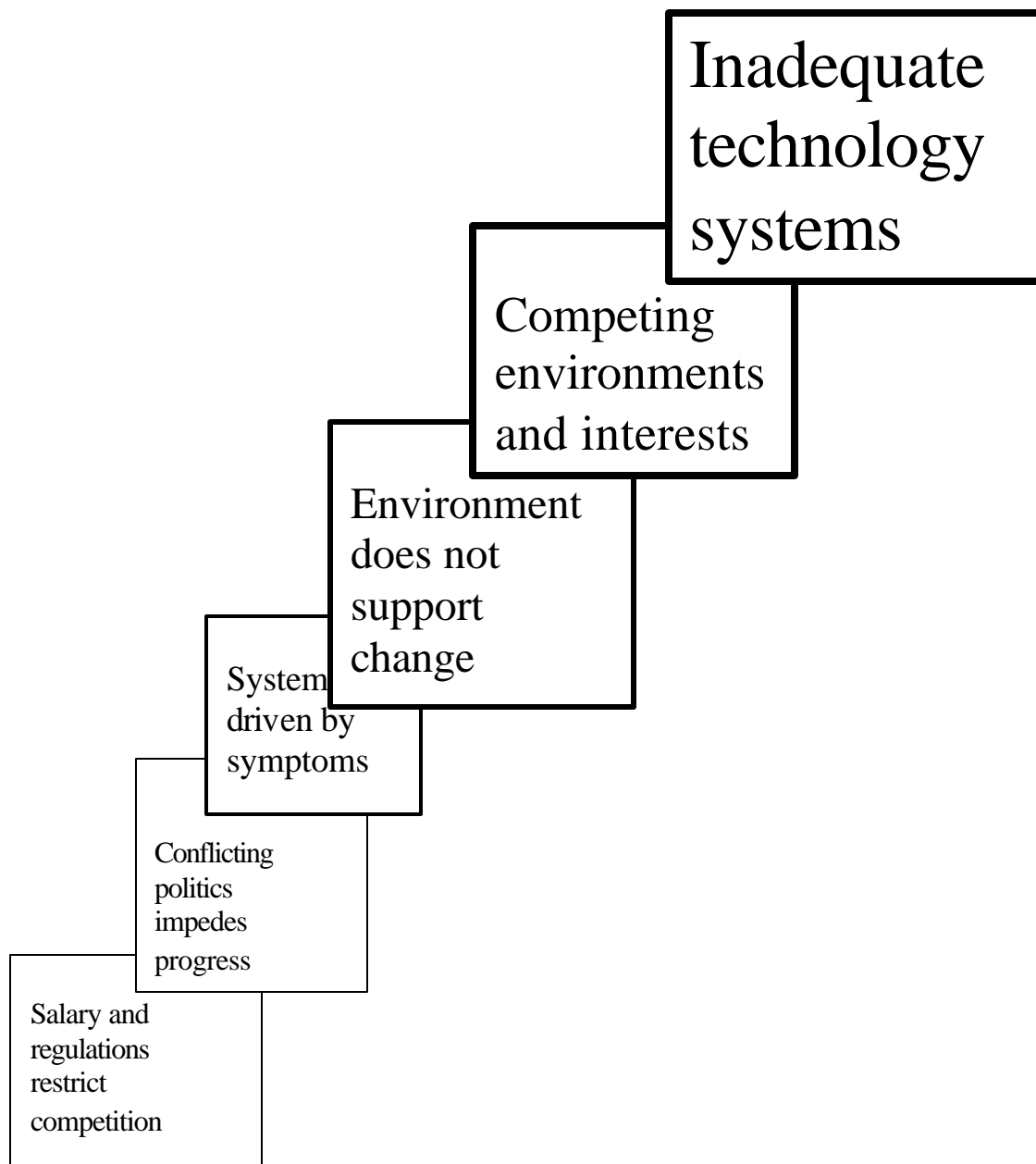
In partnership with local communities, we envision a multi-faceted health care system utilizing an indigenous approach to physical and behavioral health. Our quality system will be customer driven, and based upon outcomes. It will include:

- *Effective communication systems internally and externally*
- *Area-wide integration and access to state-of-the-art technology*
- *Resource centers for “best practices” in Indian health*
- *Support for the recruitment, development and retention of quality staff*
- *Strong leadership and advocacy to protect and advance the federal trust responsibility to provide health care to American Indians*



BARRIERS AND CHALLENGES

What is blocking us from achieving our vision now? To achieve our vision for the future, we identified each of the barriers, challenges and contradictions that prevent our progress. The better we understand our barriers the more appropriate and effective our strategies will be. The first, most immediate barrier is “inadequate technology systems”. Our second most immediate barrier is “competing environments and interests”. We must develop strategies that will circumvent or overcome these barriers to move forward. The following is a discussion of our barriers.





Discussion of Barriers and Challenges:

Each of these barriers is important and must be considered in the development of strategies. The most immediate barriers should be addressed first. To better understand what these identified barriers and challenges mean, the following summary of discussion is provided:

- **Inadequate technology systems:** Across the Bemidji Area IHS, tribes and urban programs are utilizing outdated management information systems and equipment. The “information technology” (I.T.) available to I/T/U’s has not kept pace with their needs. Better access to state-of-the-art equipment and software is identified as a challenge. Even when individual I/T/U’s expend the necessary funds to secure up-to-date systems, these systems are not necessarily coordinated across the area so that data is standardized or collated.
- **Competing environments and interests:** The Bemidji Area of the IHS represents a wide variety of interests and diversity. Often times the diverse needs of IHS service units, tribes and urban programs are not conducive to a quick solution across the board. “One size” does not fit all programs in the Bemidji Area. Even among the tribes within the Area there is a wide diversity of tribes operating large systems to tribes with very little resources. Competing interests often emerge as a challenge for seeking solutions across the Area.
- **Environment does not support change:** Like all organizations, the Bemidji Area system and each of its components can experience an internal resistance to change, even when the changes proposed are beneficial Area-wide. Participants identified the barriers of “complacency” and a sense of fatalism that the system will never change and therefore there may be little incentive to invest in changes proposed by this plan.
- **System driven by symptoms:** To achieve the shared vision articulated in this plan, the overall Indian health system (I/T/U’s) must move past a “disease orientation” and into the realm of health and wellness. Currently the vast majority of resources are expended on sick-care as opposed to health care. The direct funding and the reimbursement systems focus priority on illness instead of prevention activities.
- **Conflicting politics impedes progress:** Unfortunately, Indian health is impacted by the political process. Participants identified a trend in the federal government to avoid its responsibility for Indian health. The restrictions placed on IHS employees preventing their active advocacy of Indian health care at legislative and policy levels is problematic.
- **Salary and regulations restrict competition:** Salary and personnel limitations of the federal government system create barriers for effective recruitment, development and retention of qualified health professionals and providers. In many instances, health providers are expected to practice as “sole practitioners” in remote environments and do not have professional peers for support and communication.

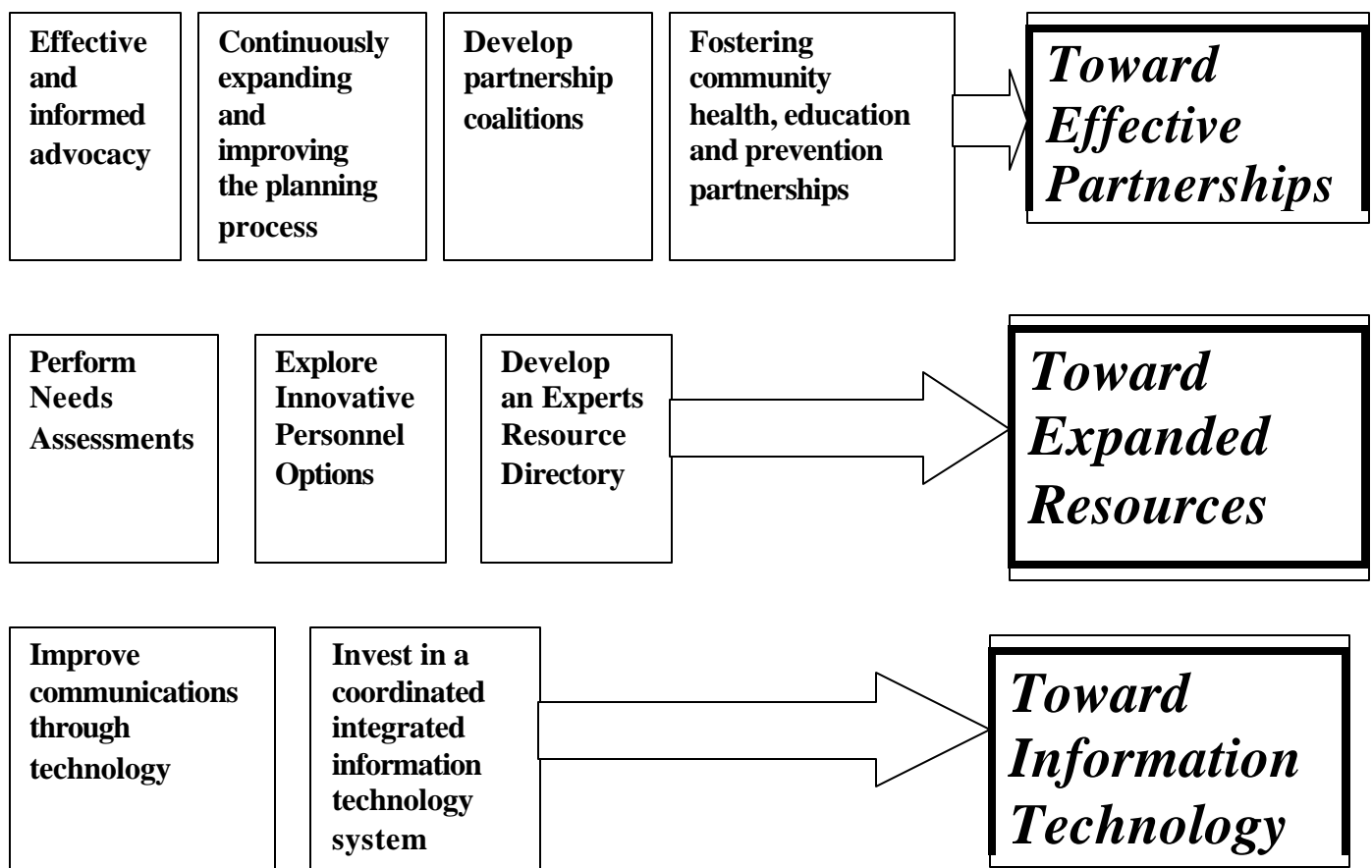


STRATEGIC DIRECTIONS

What are the actions or strategies that will address and/or circumvent the barriers and move us closer to our vision? Nine major strategies are proposed in this plan. These nine major strategies fall into three general strategic directions. Each of these nine strategies will be discussed in more detail:

Strategy

Direction





Discussion of Planned Strategies

Toward Effective Partnerships.....

- **Effective and Informed Advocacy:** Continuously educating newly elected officials at the local, tribal, state and federal levels is a critically important activity. Greater and more structured activities are proposed to keep leadership engaged in I/T/U health issues and to ensure timely and effective advocacy on Indian health issues.
- **Continuously expanding and improving the planning process:** There is a commitment among this group to bring in additional stakeholders and key decision-makers to become vested in this strategic planning process. To accomplish this, specific steps will be taken to keep this plan on the agenda of future meetings.
- **Develop partnership coalitions:** A new emphasis will be made to bring in new partners, particularly from local and regional colleges and universities.
- **Fostering community health, education and prevention partnerships:** A paradigm shift if necessary to refocus our health efforts toward the benefits of preventive activities. While not ignoring the many needs for treatment of diseases and injuries, it is crucial that preventive efforts begin to emerge as important steps to curtailing the growing health problems faced by American Indian patients in the Bemidji Area.

Toward Expanded Resources.....

- **Perform Needs Assessments:** A vast amount of high quality technical resources and personnel currently exists within the Bemidji Area I/T/U system. These technical resources have not been inventoried. If such an inventory could occur, a system could be put in place to better connect local I/T/U with other experts in the area who could assist them.
- **Explore Innovative Personnel Options:** The federal personnel system continues to be an inflexible barrier to timely and effective hiring and retention practices. It will be important to explore new ways to hire professional staff, by using tools outside the federal system, such as PL 93-638 contractors and other partners.
- **Develop an Experts Resource Directory:** Once an experts inventory has been accomplished, and system will be developed to provide I/T/U's with a directory of these resources.



Toward Information Technology.....

- **Improve communications through technology:** A more concerted effort to more efficiently utilize the internet system to communicate instantly with I/T/U's on critical issues is proposed.
- **Invest in a coordinated information technology system:** A comprehensive assessment of the current management information systems (MIS) in place across the I/T/U's is a beginning to identifying needed upgrades and effective integration strategies. Specific steps are proposed to achieve a better coordinated and compatible system for information technology. It will however, require the investment and participation of all key links from the local to Area and even national headquarters levels.



● **IMPLEMENTATION PLAN**

Each of the Strategies in our plan has been examined by the planning team and specific, measurable, realistic actions have been identified for the next one to four years. These specific action plans can and should be monitored, amended and reconsidered as the environment changes.

Effective and Informed Advocacy			
<i>Time Frame</i>	<i>Action</i>	<i>Responsibility</i>	<i>Status</i>
Jan-March 2002	<ul style="list-style-type: none">▪ Area budget formulation – involve tribal officials▪ Develop position papers to officials – individual programs▪ Directory of elected officials sent to tribal leaders▪ Educate elected officials as to health business		
April-June 2002	<ul style="list-style-type: none">▪ MAST participation by health people▪ National budget formulation▪ 437 issue presentation		
July-Sept 2002	<ul style="list-style-type: none">▪ MAST – put health issues on the agenda▪ Area/Director meetings with tribal councils▪ Presentation of BAO Strategic Plan		
Oct-Dec 2002	<ul style="list-style-type: none">▪ Local advocacy for BAO Strategic Plan<ul style="list-style-type: none">a. Health Boardb. Board of Directorsc. Health staff▪ Evaluate strategic objectives▪ Elevation of IHS Director to Assistant Secretary		
Jan-March 2003	<ul style="list-style-type: none">▪ Area budget formulation▪ National testimony – individual tribes▪ Directory of elected officials sent to tribal leaders▪ Continue education to elected officials▪ Continue position paper development		
April-June 2003	<ul style="list-style-type: none">▪ MAST Health Conference		

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	<ul style="list-style-type: none"> ▪ National budget formulation ▪ Elevate IHS Director to Assistant Secretary ▪ Identify state and federal issues 		
July-Sept 2003	<ul style="list-style-type: none"> ▪ Prepare for National testimony ▪ Area Director meetings with tribal councils 		
Oct-Dec 2003	<ul style="list-style-type: none"> ▪ Re-evaluate Strategic Plan 		
Jan-March 2004	<ul style="list-style-type: none"> ▪ Area Budget formulation ▪ National Testimony – all tribes ▪ Directory of elected officials sent to tribal leaders ▪ Continue education to elected officials ▪ Continue position paper development 		
April-June 2004	<ul style="list-style-type: none"> ▪ MAST Health Conference ▪ National budget formulation 		
July-Sept 2004	<ul style="list-style-type: none"> ▪ Area Director meetings with tribal councils ▪ Follow-up to National testimony 		
Oct-Dec 2004	<ul style="list-style-type: none"> ▪ Each tribe meet with their respective state Governor ▪ Re-evaluate Strategic Plan 		
Jan-March 2005	<ul style="list-style-type: none"> ▪ Area Budget formulation ▪ Directory of elected officials sent to tribal leaders ▪ Continue education to elected officials ▪ Continue position paper development 		
April-June 2005	<ul style="list-style-type: none"> ▪ MAST Health Conference ▪ National budget formulation 		
July-Sept 2005	<ul style="list-style-type: none"> ▪ Area Director meetings with tribal councils ▪ Follow-up to National testimony 		
Oct-Dec 2005	<ul style="list-style-type: none"> ▪ Each tribe meet with Governor ▪ Evaluate the Strategic Plan in entirety <p>Then we rested</p>		



Title			
Develop Partnership Coalition – Continuous Expansion/Improvement of Process			
<i>Timeframe</i>	<i>Action</i>	<i>Responsibility</i>	<i>Status</i>
Jan-March 2002	Write up what you are trying to accomplish.		
April-June 2002	Find out what educational opportunities are currently available in 3-state area.		
July-Sept 2002	Identify groups that should be involved in educational needs discussions – phone numbers, E-mails.		
Oct-Dec 2002	Make initial contact, provide them with what we are trying to accomplish.		
Jan-March 2003	Set up initial meetings – networking sessions. 1. Get everyone on board. 2. Figure out steps. 3. Set up workgroups – assign tasks.		
April-June 2003	Work groups to develop plans		
July-Sept 2003	Work groups to develop plans		
Oct-Dec 2003	Entire groups to meet again, report progress, brainstorm, begin specific curriculum, set-up course planning, evaluation efforts.		
Jan-March 2004	Schools agreeing to provide CTF. Programs, begin registration, funding		
April-June 2004	Registration continues, partnership continues to work on new CTF programs		
July-Sept 2004	Evaluate efforts and accomplishments		
Oct-Dec 2004	Entire group meets to continue planning		
Jan-March 2005	Schools agreeing to provide CTF. Programs, begin registration, funding		
April-June 2005	Registration continues, partnership continues to work on new CTF programs		
July-Sept 2005	Evaluate efforts and accomplishments		
Oct-Dec 2005	Trained people working towards meeting community health needs.		



Title			
Fostering Community Health Education and Preventative Partnerships			
<i>Timeframe</i>	<i>Action</i>	<i>Responsibility</i>	<i>Status</i>
Jan-March 2002	<ul style="list-style-type: none"> ▪ Round table discussion on diabetes and other identified critical conditions. ▪ Comprehensive representation ▪ Meet with MAST and other Bemidji tribes 		
April-June 2002	<ul style="list-style-type: none"> ▪ Plan – identify funds ▪ Agenda development resources ▪ Development of health resource directory 		
July-Sept 2002	<ul style="list-style-type: none"> ▪ Survey – on numbers of health educators (nutritionists, fitness directors, etc.) ▪ Diabetes conference for leaders? 		
Oct-Dec 2002	<ul style="list-style-type: none"> ▪ Identify dedicated advocates ▪ Teams/partners/meets directly 		
Jan-March 2003	<ul style="list-style-type: none"> ▪ Meet with tribal colleges ▪ Roundtable discussion ▪ Mental health – new topic 		
April-June 2003	Plan Agenda – who?		
July-Sept 2003	Mental health conference and follow up with diabetes		
Oct-Dec 2003			
Jan-March 2004	New topic? What are I/T/U's Needs/Goals		
April-June 2004	Reference area needs assessments		
July-Sept 2004	<ul style="list-style-type: none"> ▪ Develop educational material ▪ Follow up with mental health ▪ Follow up with diabetes 		
Oct-Dec 2004			



Title			
Needs Assessment			
<i>Timeframe</i>	<i>Action</i>	<i>Responsibility</i>	<i>Status</i>
Jan-March 2002	<ul style="list-style-type: none"> Define needs assessment Review previous assessments/data Who are we asking? How is this going to be done? Who will decide who will be doing the assessment? <p>Informed process at I/T/U meeting</p>		
April-June 2002	<ul style="list-style-type: none"> Define needs assessment Review previous assessments/data Who are we asking? How is this going to be done? Who will decide who will be doing the assessment? <p>All information be made available to I/T/U's patients</p>		
July-Sept 2002	<ul style="list-style-type: none"> Develop needs assessment instrument Test instrument and validate Agenda item at I/T/U meeting 		
Oct-Dec 2002	<ul style="list-style-type: none"> Develop needs assessment instrument Test instrument and validate 		
Jan-March 2003	<ul style="list-style-type: none"> Distribute and administer Follow up to insure 100% participation 		
April-June 2003	<ul style="list-style-type: none"> Distribute and administer Follow up to insure 100% participation 		
July-Sept 2003	Begin analysis		
Oct-Dec 2003	<ul style="list-style-type: none"> Begin analysis Distribute final report 		



Title			
Explore Innovative Personnel Options			
<i>Timeframe</i>	<i>Action</i>	<i>Responsibility</i>	<i>Status</i>
Jan-March 2002	<ul style="list-style-type: none"> Involve recruiter/scholarship commitment – for hiring practices (streamlining) Develop problem statement: purpose + scope + goals + action plan Develop grant chart 		
April-June 2002	<ul style="list-style-type: none"> Re-evaluate and assess BAO hiring process Locate bottlenecks Look at other agencies' personnel offices 		
July-Sept 2002	<ul style="list-style-type: none"> Contact Albuquerque O.P.M. (CRT) Re-align with Albuquerque?, Oklahoma? (is there a choice?) 		
Oct-Dec 2002	<ul style="list-style-type: none"> Re-align with Albuquerque?, Oklahoma? (is there a choice?) 		

Title			
Resource Experts Directorate			
<i>Timeframe</i>	<i>Action</i>	<i>Responsibility</i>	<i>Status</i>
Jan-March 2002	<ol style="list-style-type: none"> Perform skill/talent inventory <ol style="list-style-type: none"> Talk to tribal leaders/health directors – process/need Design Questionnaire (BAO) 		
April-June 2002	<ol style="list-style-type: none"> Check with <u>stakeholders</u> and re-do each year (MN, WI, MI Health Networks, Intertribal, Service Units, Urban, etc. and tribal management) 		
July-Sept 2002	<ol style="list-style-type: none"> Administer Questionnaire and summarize (matrix) (BAO – keep contacts) 		
Oct-Dec 2002	<ol style="list-style-type: none"> Report(s) distribution – TAB, GLITC Board, MITC, Annual I/T/U meeting (initial help, known information) <ol style="list-style-type: none"> Confirm where are 		



	<ul style="list-style-type: none"> ii. Next step iii. Buy in for ... 		
Jan-March 2003	<ul style="list-style-type: none"> 2. Develop process for supporting and using matrix <ul style="list-style-type: none"> a. Policies/Procedures – Draft (BAO) (simple, not burdensome) <ul style="list-style-type: none"> i. Costs/support – how handled/keep expertise ii. Process for help iii. I.D. who does it (keeps system going) – central mechanism 		
April-June 2003	<ul style="list-style-type: none"> b. Update all stakeholders – input and reuse 		
July-Sept 2003	<ul style="list-style-type: none"> c. Final report <ul style="list-style-type: none"> i. Whole system - matrix/policies/procedures ii. How would work – final buy-in all stakeholders, including tribal management 		
Oct-Dec 2003	<ul style="list-style-type: none"> 3. Begin Implementation Planning (assuming approval) <ul style="list-style-type: none"> a. Clarify conditions of participation for different matrix services 		
Jan-March 2004	<ul style="list-style-type: none"> b. Train all who might want to use matrix services (in the matrix and policies/procedures and conditions for participation in different services) 		
April-June 2004	<ul style="list-style-type: none"> c. Prepare central coordination – BAO dollars <ul style="list-style-type: none"> i. Mechanism to update matrix, policies/procedures, conditions for participation ii. Keep a library – policies/procedures, etc. 		
July-Sept 2004	<ul style="list-style-type: none"> d. Start the matrix and market its use 		
Oct-Dec 2004	<ul style="list-style-type: none"> d. Continued.... 		
Jan-March 2005	<ul style="list-style-type: none"> 4. Evaluate <ul style="list-style-type: none"> a. Evaluate initial comments/problems 		
April-June 2005	<ul style="list-style-type: none"> b. More in-depth evaluation – design instrument 		
July-Sept 2005	<ul style="list-style-type: none"> b. Continued.... 		



	c. Do evaluation and feedback to all stakeholders		
Oct-Dec 2005	d. How well retaining key talent (future)		

Invest In a Coordinated/Integrated I.T. System			
<i>Timeframe</i>	<i>Action</i>	<i>Responsibility</i>	<i>Status</i>
Jan-March 2002	<ul style="list-style-type: none"> Workgroup for needs assessment (inventory) of I.T. <ol style="list-style-type: none"> Formation of the I.T. systems workgroup co-chaired by Tribal/Urban IHS staff resource only First conference call rep. by the end of March 2002 Define charge, expectations, knowledge and skills of users, work plan, tech. people, etc. 		
April-June 2002	<ul style="list-style-type: none"> Assessment tool developed by workgroup (multi-disciplinary) by June 30, 2002 Include cost/dollar figures and who are your system owners (handles it, etc.) Reporting power to A.D. with recommendations “Redefine what Area I.T. Department does”. 		
July-Sept 2002	<ul style="list-style-type: none"> Assessment mailed out and returned to Chairs of workgroup Determine who will collate, date and disseminate Needs assessment completed 		
Oct-Dec 2002	<ul style="list-style-type: none"> Report and recommendations available to I/T/U’s at fall meeting Disseminate to I/T/U’s Business plan for I.T. presented to A.D./TAB 		
Jan-March 2003	<ul style="list-style-type: none"> Develop a “base-line” that all I/T/U’s must have for operation Include technical, basic knowledge for users, staff, hardware and software 		



April-June 2003	<ul style="list-style-type: none"> ▪ Be proactive in obtaining “other” funding: grants, tribal funds, other federal and state funding – ongoing process through 2006. 		
July-Sept 2003	<ul style="list-style-type: none"> ▪ Be proactive in obtaining “other” funding: grants, tribal funds, other federal and state funding – ongoing process through 2006. ▪ Begin implementation process for those that can – technical leaders <ol style="list-style-type: none"> 1. Technical leaders 2. Trained site managers 3. Dedicated MIS staff 4. Teleconferencing/video conferencing 5. Telemedicine 		
Oct-Dec 2003	<ol style="list-style-type: none"> 6. Package ownership 7. Connectivity 8. Training 9. List server 10. Increased use inter/intranet <ul style="list-style-type: none"> ▪ Be proactive in obtaining “other” funding: grants, tribal funds, other federal and state funding – ongoing process through 2006. 		
Jan-March 2004	<ul style="list-style-type: none"> ▪ Redefine the “base line” to include new technologies (ongoing process) ▪ Obtain funding ▪ Be proactive in obtaining “other” funding: grants, tribal funds, other federal and state funding – ongoing process through 2006. 		
April-June 2004	<ul style="list-style-type: none"> ▪ I.T. committee ongoing function ▪ Process continues – everyone should be connected in 4 years ▪ Be proactive in obtaining “other” funding: grants, tribal 		



	funds, other federal and state funding – ongoing process through 2006.		
July-Sept 2004	<ul style="list-style-type: none">▪ (FY 2006) Target Goal▪ Be proactive in obtaining “other” funding: grants, tribal funds, other federal and state funding – ongoing process through 2006.		
Oct-Dec 2004	Be proactive in obtaining “other” funding: grants, tribal funds, other federal and state funding – ongoing process through 2006.		



Attachments

Vision Workshop Brainstorming Notes

Obstacles Workshop Brainstorming Notes

Strategic Directions Workshop Brainstorming Notes



VISION

A multi-faceted health care system utilizing an indigenous approach to physical and behavioral health in partnership with the community		A customer driven, outcome based quality system	An effective communication system internally and externally	Equitable access to area office services	Advocacy leadership	I/T/U-wide access to state of the art technology integrated state of the art information management system		Resource centers for innovation and best practices	A system to support recruitment, development and retention of qualified staff
Treatment funds - Mental health - Adult alcohol	Re-focus from illness to wellness	“On-the-ground” Effectiveness at local level	Clarified communication with state and other entities	Accessibility of area office (Bemidji travel hardship)	Advocacy	Integrated information systems	Improved technology	Innovation	Effective and timely hiring of qualified staff
Public safety	Improved collaboration on “Wellness” and tapping into all resources	Accountability determined by I/T/U’s	Improve communication at all levels throughout the I/T/U’s		Public information and advocacy coordination	MIS support	State of the art technology	Innovative business models	Recruit/retain the best and brightest
Environmental health	Mutual understanding of health needs				Retain trust responsibility	Integrated administrative systems	Information technology involved in business decisions	Develop centers of excellence (within area)	Recruitment for all I/T/U health professions
Expansion of home health services	Improved patient involvement				Leadership on specific public health issues	I/T/U “integrated” data systems	Increased use of technologies ... teleconferencing, telemedicine, etc.	Professionalism	Training technical assistance



	Diverse community involvement				Education public relations	MIS Infrastructure "Rebuild & support" to I/T/U's	State of art technology development and support	Core group of consultants to IHS/Tribal/Urban	Training for staff
						Re-evaluate RPMS system	Systems that work	Expansion of Epi centers	One position in area office dedicated to urban program
						Implement NT or AIX systems at all DOS sites	Standardize/ improve IT systems (compatibility)	Partnership development with other health organizations – ie. state, university, federal	Surveillance of health status
						Business office coordination		Explore "innovative" efficiencies	



BARRIERS AND CHALLENGES

1. Inadequate technology systems	2. Competing environments and interests	3. Environment doesn't support change	4. System driven by symptoms	5. Conflicting politics impedes progress	6. Salary and Regulations Restrict competition
Outdated MIS systems/equipment	Diversity of communities (and diversity of needs)	Complacency	Resources (human, \$'s) currently focused on hospital, clinic – little on public health. Need <u>REAL</u> commitment (ex. Hiring a fitness coordinator vs. a dentist, nurse or doctor)	Political issues	Area: recruitment – retention Barrier: Practitioners – providers expected to practice as solo practitioners in many cases. No peers to bounce ideas off/lack of communication and support
IHS data system not keeping up with the times – focus on <u>their</u> needs (the I) vs. the needs of the T/U's in the I/T/U	Competing priorities within I/T/U	Sense of fatalism	Focus on illness instead of health	Federal government trend toward avoiding responsibility for Indian health care	<u>Recruitment</u> regulations competition
Access to state of the art technology	Diversity of I/T/U	Resistance to change	Health care reimbursement system does not reward innovation or prevention	IHS prohibited from lobbying	Can't compete with private sector
State of the art becomes obsolete tomorrow	Consensus on customer needs and quality/ outcome measures	Stigma with disease states dehumanizing			Competing with private sector for salary
Much money being spent by individual I/T/U units. Exists <u>NO</u> current coordination to standardize collecting, collating data		Providers and IHS staff are strangers to the community			Government and many tribal systems of hiring are antiquated – can't compete with the "business" environment
Incompatible hardware and software systems among tribes					Staff training "no resources"
No systems baseline					



(hardware/ software)					
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STRATEGIC DIRECTIONS

Effective and informed advocacy	Continuously expanding and improving the process	Develop partnership coalitions	Fostering community health, education and prevention partnerships	Perform needs assessments	Explore innovative personnel options	Improve communication through technology	Invest in a coordinated integrated information system	Resource experts directorate
Continuing educating our political leaders on our needs	Evaluate outcomes annually	Emphasize partnership coalition development with tribal colleges, univ., state government	Promote prevention as a cost savings	Identify needs of all I/T/U's	Explore special pay incentives	Update I/T/U's on legislative issues via E-mail	Assess the MIS needs & infrastructure for all I/T/U's and share expertise	Do organization skills inventory
Greater involvement in MAST (health dir)	Commitment to change "change starts with me"		Refocus prevention wellness efforts to whole community (not just high risk)	Assess & develop a database of strengths/ needs of experts to assist each other (I/T/U's)	Advocate concerns to Secretary of H&HS regarding OPM's policies	Commit unexpected monies to assure every employee in BA has access to E-mail, internet, etc.	Software package ownership at local level "supervisors"	Develop a skills matrix of area expertise
Tribal leaders utilize E-mail to communicate with congress	Bring the right people to the table		Use behavioral health staff to change behavior	Do needs assessment for all programs	Improve competition in hiring by seeking using innovative hiring practices – ie. 638, ASC's, find partners to do this	Better utilization of internet – policies, IHS Website, congressional actions, etc.	Refine & expand teleconferencing	Continue to share knowledge and expertise with each other
Greater leadership involvement			Consortium grants to fund develop curriculum to work with tribal colleges to training fitness/	<u>Before it is too late!</u> Aggressive planning with respect to all user needs on		Set up area wide list-server to disseminate information ("two-way")	Identify & elevate all programs to baseline	Identify talent wherever it is (Area Office – in Tribal – I/T/U)



			trainers community activist	technology, MIS, business systems				
Lobbying for dollars to update our systems			Project WOLF at every school	<u>Communicate</u> I/T/U's individual needs & share info!			Additional dollars coming to area needs to be prioritized	Obtain support from senior management/ tribal leaders share expertise
Area office coordinate with local leaders (tribal) to promote and support advocacy			Need to prioritize prevention in the annual budget formulation	<u>Promote & initiate</u> proactive needs assessment & expert utilization			IT: make the investment	Determine & publish the list of experts for all I/T/U's use
BAO staff be more proactive in providing information to tribal leaders			Educate your community in healthy living				Establish MIS hardware & software baseline	Seek innovative ways to stabilize/ retain talent identified
			Educating community on health issues				RPMS & other systems need to be able to communicate	Identify experts to be resources
			On-going education plan				Technical leader at area rather than RPMS Manager	Create BAO library (Bios, by-laws, policies, funded grants)
							Dedicated MIS staff at all sites	
							Obtain funds to meet MIS needs	
							Trained site managers at local I/T/U sites	

